I am waiting in the car, and waiting to get into the Red Lobster was a member of the Pennsylvania National Guard. He was there with his family. I took the keys out of the car. I ran up to him real quick. I was dressed not like a Congressman, I was just like a regular guy, just a regular shirt and I had shorts on him. I said to him, I said, hey, troop, I just want you to know that I appreciate your service to our country.

□ 2215

Then we started talking a little bit and at the end I told him I was a congressman and gave him my card. I said, If there is anything I can ever do, you let me know, and I will keep you in my prayers.

He got choked up and said, Thank you, Mr. Congressman, I appreciate that.

I told him, Just call me ''Patrick.'' You don't have to call me ''Mr. Congressman.''

We have meetings in Washington on the Armed Services Committee. I am also honored to serve on the Intelligence Committee. We also have meetings of the Blue Dog Democrats. We talk about these things at the Blue Dog Democrat meetings. We care with every fiber of our being for these troops.

Mr. Speaker, I was at a meeting with the Blue Dogs at 5:00, or 1700 as they say in military time. I passed around a sheet talking about how can we take care of our troops.

When troops get orders to deploy, sometimes they don't have a lot of time. Sometimes they have rent. Well, they don't need to have an apartment if they are in Iraq or Afghanistan for 15 months, so they want to break their lease. There is Federal law, there is the Servicemembers Civil Relief Act, so they can break their lease. It is a commonsense bill that this Congress passed. There is a bill that says expand that now to allow our troops who have cell phones, a 1-year or 2-year program, why not allow the troops to break their cell phone contracts. Their cell phones are from Verizon or Cingular, and they don't have cell phones over in Baghdad or in Afghanistan. That commonsense approach says let them break their cell phone lease under Federal law. That is the type of backing that they need.

To get back to the Iraq Accountability Act, Mr. Speaker, you look at what this Iraq Accountability Act has done to shed light on fraud, waste and abuse. The report that I just mentioned about the 190,000 weapons is a disgrace when you talk about accountability.

Last month, there were a total of 73 criminal investigations related to contract fraud in Kuwait, Iraq, and Afghanistan; 73 criminal investigations. That is 73 investigations on contracts totaling $5 billion. That is billion with a ''b,'' Mr. Speaker. The charges so far identify more than $15 million in bribes. If there is ever a time for a new direction in Iraq, now is the time, Mr. Speaker. If there is ever a time for accountability and oversight, now is the time, Mr. Speaker.

And as long as my fellow Blue Dogs and I are here in the House's great body, we will keep calling, we will keep fighting for what American families and what American troops deserve, and that is civilian leadership that is just as smart and savvy as those troops on the ground.

I want to thank again the gentleman from Arkansas, Mr. ROSS, for allowing me to speak. I appreciate your leadership role with the Blue Dog Democrats.

When I was home, Mr. Speaker, and I was talking to those families in Bucks County, many told me, Mr. Congressman, I like that are you a Blue Dog and that you are standing up for fiscal responsibility and you stand up for change. I like the fact that you stand up for a new direction. I like the fact that you talk about that $9 trillion in debt that we have right now and how it is immoral to pass it on to our kids, because it is. I like the fact that the Blue Dogs stand up and say you have a pay-as-you-go system, not a pass-the-buck system. That is what happened before. That's leadership.

And, Mr. Speaker, to the gentleman from Arkansas, to my colleague from the great State of New York, it is a great honor to be among your midst as a fellow Blue Dog.

Mr. ROSS. I thank the gentleman from Pennsylvania for his insight as someone who has served in the war in Iraq as a captain in the Army, and we appreciate his service here in the Congress and his insight into helping us draft proposals like H.R. 97 to restore accountability and common sense on how your tax money is being spent in Iraq and ensuring that it is directed towards our brave men and woman in uniform and protecting them and keeping them safe.

Mr. Speaker, it is time for a new direction in Iraq, and that is what this Blue Dog hour has been about this evening. I thank my colleagues who have joined me.

If you have any comments or questions, you can e-mail us at BlueDog@mail.house.gov. That is BlueDog@mail.house.gov. We stand here on behalf of 47 fiscally conservative Democratic Blue Dog members that make up the Blue Dog Coalition.

## HEALTH CARE

The SPEAKER pro tempore. Under the Speaker's announced policy of January 18, 2007, the gentleman from Texas (Mr. BURGESS) is recognized for half the time before midnight, which is approximately 50 minutes.

Mr. BURGESS. Mr. Speaker, I wanted to come to the floor of the House this evening and do as I do many times late in the day after the official business of Congress has concluded and talk a little bit about health care.

Health care is going to be one of the things that we hear about a lot over the next 14 to 16 months before the next Presidential election. There are a lot of areas that I could discuss, but I want to concentrate on two areas. Those are the physician workforce itself, who is actually going to provide the care. And we are coming up on the 4 year anniversary of a law that was passed back in my home State of Texas that dealt with significant medical liability reform, and I would like to spend a few minutes talking about that also this evening.

We have to, as a Nation, look at the effects that some of the policies that we have generated here in Congress, quite honestly some of the policies that we have had that have been prevalent in our Medicaid and Medicare system that have resulted in physicians not continuing their practices, or, I am afraid to say, in some instances young people even deciding that the practice of medicine may not be for them.

Now, right before we left on break, we had an opportunity to reauthorize the Children's Health Insurance Program. It was a program that is now going on 10 years since its inception, passed by a Republican Congress, signed into law by a Democratic President, so truly a bipartisan effort 10 years ago. It is going to expire at the end of this month.

Mr. Speaker, every one of us who stood in this Chamber and raised their right hand and swore an oath on January 3 that we were going to do the country's business this year, every one of us knew that the Children's Health Insurance Program expired at the end of the fiscal year, which is less than 30 days away.

Still, we waited until the absolute last minute before we broke on our August recess. A bill came to the House floor after some fairly contentious committee proceedings. Regular order in the committees was not adhered to. We didn't go through a subcommittee process. We got a big bill dumped on us right before we had a full committee hearing, and as a consequence, there was no time to evaluate that in my Energy and Commerce Committee. It was brought to the House floor and it passed largely on partisan lines. It is strikingly different than the bill passed in the Senate, and the President had already indicated that he would not sign but veto the bill passed in the Senate. And I have to believe that the bill that was passed at the last minute, in the waning moments before the August recess by the House of Representatives, I have to believe that the President feels the same way about that bill as well.

It is significant, of course, because there are a lot of people who depend on the State Children's Health Insurance Program.

Mr. Speaker, I don't think I can name one person in this body on either side of the aisle who wouldn't be for a reauthorization of this program if we could simply sit down and do it in a reasonable fashion. Unfortunately,

that was not available to us. So now, we will go through and watch the drama of naming conferees and having conference committee hearings and we will have a bill that will come to us which may or may not be acceptable. I have to believe at the end of the day it is going to be very, very difficult for us to pass a conference report that the President can sign before the 30th of September.

There was a lot of good stuff in the bill. There were a lot of good things in the bill that should have been tackled as separate entities, not rolled into this one big amalgam that was spread out before us right before the end of the session.

One of the things that was addressed in the bill that I was grateful for was an attempt to deal with one of the things that has been a very contentious issue the entire 5 years I have been in this Congress, and that is the issue on physician payments. But as a consequence of how the bill has been handled and how the bill was brought to the floor of the House and how the bill was pushed through the committee process, again it is unlikely that the reasonable things that were in the bill will ever see the light of day and those things will still be requiring our attention before we get to the end of this year.

Mr. Speaker, one day right before Chairman Alan Greenspan concluded his tenure as chairman of the Federal Reserve, he came and talked to a group of us here on Capitol Hill, and the question came up: Mr. Chairman, what do you see about the problems ahead for the Medicare program?

Chairman Greenspan thought about it and he said: I think when the time comes, you will make the necessary hard choices that are required to keep the Medicare program solvent. He then went on to say what concerns me more is will there be anyone there to deliver the services when you actually require them.

Those have been words that have stuck with me since the time Chairman Greenspan came and talked to us early that morning. He has since been back and talked to a different group, and I asked him if he feels the same way today, and the answer was not only yes, but yes and more so.

Back in my home State of Texas in March, the lead article in a magazine that is published by the Texas Medical Association called Texas Medicine was an issue about running out of doctors and how medical schools were having to work extra hard to develop new doctors, and since this was a Texas-based article, to keep those doctors practicing in Texas.

There is a series of three bills that I have recently introduced this year to try to deal with the oncoming physician manpower shortage as I see it. Now, the first of these bills would be to deal with graduate medical education and some enhancements to graduate medical education.

This would help younger doctors with the creation of new residency programs. A strange thing about doctors is, and one of the things that was stressed in this article in Texas Medicine, we have a lot of inertia. A doctor is very likely to go into practice within a 50- or 100-mile radius of where that doctor does their residency. They don't show a lot of originality of thought when it goes into establishing that private practice. They tend to stay where they were in training.

There are a lot of reasons for that: Comfort and knowledge of the other practitioners in the medical community, knowing those pathways for referral, perhaps even already having established some pathways for referral sources while in the residency program. For whatever reason, doctors tend to practice very close to where they trained in residency.

But a lot of smaller and medium-sized communities with hospitals that have a patient load that would sustain a residency program, in fact, don't have a residency program. The barrier to entry for a hospital like that to set up a residency program is quite expensive, and so the barrier to entry is significant. And as a consequence, those residency programs are just not done. They are not established.

The bill I proposed is designed to get more training programs into areas where medical service is less than optimal, perhaps rural or inner city areas, to get young doctors training in locations where they are actually needed.

□ 2230

Now, the Graduate Medical Education Enhancement Act, as introduced, would develop a program that would permit hospitals that do not traditionally operate a residency program, it would allow them the opportunity to start a residency training program to begin building that physician workforce of the future.

Now, on average, it costs about $100,000 a year to train a resident, and that cost for a smaller rural hospital can, in fact, be prohibitive. Because of the cost consideration, the bill would create a loan fund available to hospitals to create residency training programs, again where none has operated in the past. The program, of course, would require full accreditation and be generally focused in rural suburban, inner urban areas, areas where, again, the need is greatest.

Now, a diverse group of professional organizations, including the American College of Emergency Physicians and the American Osteopathic Association, have been very supportive of this legislation, and I think realistically this is something that this Congress could take up and could agree upon in a bipartisan fashion, and in fact, we likely could do that before the end of the year if we were to set our minds to it.

But locating young doctors where they're needed is part of solving an impending physician shortage that realistically could encompass the entire health care system in the country.

Another aspect that needs to considered is actually training the doctors for those high-need specialties. Now, a second bill introduced, H.R. 2384 for those of you who are keeping score at home, the High Need Physician Specialty Act of 2007, establishes a mix of scholarships, loan repayment funds and tax incentives to entice more students to medical school and to create incentives for students and newly minted doctors. This program will establish a repayment program for students who agree to go into high-need specialties, again family practice, internal medicine, emergency medicine, general surgery, OB/GYN, and practice in a medically underserved area. It will be a 5-year authorization at $5 million per year.

This bill would provide additional educational scholarships in exchange for a commitment, and that commitment is to serve in a public or private, nonprofit health facility determined to have a critical shortage of primary care physicians.

Other prominent groups such as the American Association of Retired Persons and the American College of Physicians support this high-need physician specialty legislation, and Mr. Speaker, I would just parenthetically point out, we did earlier this year a similar bill to offset some of the costs of educating young lawyers. And perhaps we should devote some similar attention to young physicians as well.

But you know, Mr. Speaker, in addressing the physician workforce crisis, in a little bit we're going to focus on some liability concerns in reforming the liability system. I've already talked about placement of doctors in locations in greatest need and the financial concerns of encouraging doctors to remain in high-need specialties.

But the other thing we've really got to focus on is perhaps the largest group of doctors, and I know for a fact it's the largest and still growing group of patients, that group that's encompassed by the so-called baby boom generation and their effect on the entire Medicare program.

We've all heard it before. The baby boomers are going to grow older and retire, and the demand for services are going to go through the roof, and if the physician workforce trends continue as they are today, that is, a downward trajectory, we may not be talking about just simply funding a Medicare program. We may be wondering where all the doctors are who are supposed to be taking care of those seniors.

Again, I allude back to the comments of Chairman Greenspan, and I think those comments echo very strongly today. But year over year, one of the reasons for this happening is year over year there's a reduction in reimbursement payments from the Center for Medicare and Medicaid Services to doctors, to physicians for services that they provide to Medicare patients.

Now, Mr. Speaker, this is not a question of doctors just wanting to make more money. It's about stabilized repayment for services that have already been rendered, and it isn't affecting just doctors. This problem affects patients and becomes a real crisis of access.

Now, Mr. Speaker, not a week goes by that I don't get a letter or a fax from some doctor back in Texas who said, you know what, I have just had enough, and I am going to retire early or I'm no longer going to see Medicare patients in my practice or I'm going to restrict those procedures that I offer to Medicare patients.

Mr. Speaker, I know this is happening because I saw it in the hospital where I practiced in my own hospital environment before I left the practice of medicine to come to Congress back in 2003, but I hear it in virtually every town hall that I do back in my district. Someone will raise their hand and say how come on Medicare you turn 65 and you have to change doctors? Mr. Speaker, the answer is because their doctor found it no longer economically viable to continue to see Medicare patients because they weren't able to cover the cost of delivering the care.

Medicare payments to physicians are modified annually under something called the sustainable growth rate formula. You probably hear it referred to in the Capitol as the SGR formula. There are flaws in this formula. There's flaws in the process, and the SGR-mandated physician fee cuts in recent years have only been averted at the last minute by fixes that Congress does legislatively, usually at the eleventh hour right before we wrap things up at the end of the year.

If no long-term congressional action plan is implemented, the SGR, the sustainable growth rate, formula will continue year over year to mandate fee cuts. Mr. Speaker, let me also point out that these last minute fixes, Mr. Speaker, they're not free. They add to the cost of ultimately repealing the SGR.

One of the things we hear over and over again, it just costs too much, we can't repeal the SGR. But every year that we delay fixing the SGR, we add billions and billions of dollars to the total cost of ultimately repealing this sustainable growth rate formula, the formula under which no physician can continue to practice and see Medicare patients.

Mr. Speaker, unlike hospital reimbursement rates, which closely follow what's called the Medicare economic index, that's basically a consumer price index or cost of living adjustment, however you want to look at it, it's called the Medicare economic index which measures the cost of providing care. What is the cost of input for taking care of a patient in either a hospital or medical practice setting? But physician reimbursements don't track the Medicare economic index.

In fact, Medicare payments to physicians at present only cover about 65 percent of the actual cost of providing services. Mr. Speaker, can you imagine anyone in business or any industry and ask them to continue in business if they receive only 65 percent of what it costs them to deliver whatever good or service it is that they're providing? There's a recipe for financial disaster if you're in that sort of business. If you're losing 35 cents out of every dollar that is spent on health care, guess what; you don't make it up in volume.

Well, currently, the sustainable growth rate formula links physician payment updates to the gross domestic product, and Mr. Speaker, for the life of me I don't understand that. There is no relationship to the gross domestic product to the cost of providing care to America's most vulnerable patients, most complicated patients, our senior citizens.

But we hear it over and over again. Simply repeal of the sustainable growth rate formula is cost prohibitive, but you know, maybe if we do it over time, maybe if we don't try to do it all at once right here and now, maybe there is a way forward in this.

Last year, I introduced a bill, H.R. 5866, which sought to repeal the SGR straight up, just get rid of it, and the cost for that was scored by the Congressional Budget Office as being $218 billion. Reality is today, because of the cost of doing nothing, that repeal would likely cost in the neighborhood of $265- to $275 billion over that 10-year budget window, that elusive 10-year window that we're always talking about.

Mr. Speaker, paying physicians fairly will extend the career of many doctors who are now in practice, who otherwise some mornings may wake up and just opt-out of the Medicare program and may seek early retirement. They may run for Congress or they may restrict those procedures that they offer to their Medicare patients. You know, I talked about ensuring an adequate physician workforce. If we were to fix this problem with the sustainable growth rate formula, if we were to evolve to a Medicare economic index way of paying for those costs of actually delivering the care, maybe then older Americans could have the insurance that they will have the access to the coverage that they want, they need and that they expect.

Mr. Speaker, we hear a lot in this body about things like pay for performance. Well, Mr. Speaker, I would just ask the question, how does driving out perhaps some of the most capable doctors, doctors who are mature in their practice, who have developed practice patterns that are economical, they've developed efficiencies in their practice, that they are the doctors who are the most proficient in the operating room, the ones that will come to a diagnostic conclusion quickest, if we drive all of those doctors out of practice, how much are we going to have to pay for performance in that scenario?

Mr. Speaker, in a bill that I introduced, H.R. 2585, the physician payment stabilization bill, the sustainable growth rate formula would be repealed in 2 years' time, in 2010. That's 2 years from now, and by some other budgetary techniques, resetting the baseline in the SGR formula, provide physicians the protections that they would need for 2008 and 2009 so they would not see reductions in reimbursements over those years and would then provide them the sustained protection of the Medicare economic index in 2010 and beyond.

Now, recently, again the Congressional Budget Office estimated that the practical effect of my payment bill would bring a 1.5 percent update in 2008 and a 1 percent update in 2009 and then a complete elimination of the sustainable growth rate formula in 2010. The CBO also calculates an additional savings of $40 billion off of the total price tag of the SGR elimination.

Additionally, Mr. Speaker, we always hear how things like improving health information technology and, indeed, reporting and incorporating some performance measures will lower the cost of care. Included in this bill would be two voluntary programs which would augment physicians' payments 3 percent for a physician or group who instituted some changes in their information technology and a 3 percent update for physicians that would participate in a voluntary reporting process, for those individuals who want to further offset the damaging effects of what the last 10 years of cuts in the sustainable growth rate formula have brought to their practices.

But Mr. Speaker, the concept here is very simple. It's so simple that sometimes we forget what the concept is. The concept is stop the cuts and repeal the SGR formula. It's the only logical, economically viable solution, and Mr. Speaker, it is the only solution that has in its focus the long-term problem.

Again, a lot of people say why not just bite the bullet and go with the full repeal of the SGR and get it out of the way. I tried that last year. I really found no enthusiasm for it, either in this body or any of the professional organizations that are out there that ostensibly would be there to help push a concept like this.

And Mr. Speaker, again, on paper it costs a tremendous amount of money to do that, and we're required here in Congress to live under the rule of the Congressional Budget Office to find out how much things cost: If we're going to be spending the taxpayers' money, how much are we going to spend, over what time will we spend it.

Because of the constraints of the Congressional Budget Office, we're not allowed to do what's called dynamic scoring. We can't look ahead and say, you know, I think if we do things this way, we're actually going to save some money. You can't do that under the current Congressional Budget Office constraints, and maybe that's okay, but it certainly puts some limits on some of the things that you're able to do.

Mr. Speaker, case in point is the trustee's report from Medicare that came out earlier this summer, and the bad news is that Medicare is still going broke. But the good news is that Medicare is going to go broke a year later than what they told us, 2019 instead of 2018.

The reason for that, Mr. Speaker, is because 600,000 hospital beds in 2005 were not filled in the Medicare program. Those were beds that were expected to be filled, but in fact, those patients weren't admitted to the hospital. Because why? Doctors are doing things better. Doctors are doing more procedures and offering more in their offices, in their ambulatory surgery centers. Because of the way that the Medicare payment works in Part a, Part B, Part C and Part D, money that we save for Part A, because we spent more in Part B, never gets credited to Part B.

□ 2245

That's why we have such a difficulty in offsetting these costs. This bill that I have introduced would actually take those savings, sequester them, aggregate them, protect them, and 2 years later, cost savings from part A would, in fact, be applied to part B to bring down the cost of repealing the sustainable growth rate formula.

One of the main thrusts of the bill is to require the Centers for Medicare & Medicaid Services to look at the top 10 things that cost the most amount of money each year, to require the CMS to adopt reporting measures relating to these top 10 conditions. These things have already been developed. This is not reinventing the wheel.

The American Medical Association and several medical consortia have already developed reporting measures on the 10 conditions that drive medical costs so high.

We all remember the famous bank robber Willie Sutton. When they asked him why does he rob the bank, he replied because that's where the money is. Let's go where the money is. Let's go with these top 10 things where the greatest amount of money is spent because that's where the greatest amount of savings can occur.

If we can deliver care in a more timely fashion, if we can improve outcomes, we are actually going to spend less. If we spend less, let's give credit where credit is due. That's not by building up the trust fund in part A; that's by buying down the SGR formula in part B and ultimately repealing it once and for all.

The same considerations may apply to the Medicaid program as well, so it will be a very useful exercise to go through and identify those top 10 conditions, and where the savings can be the most easily gathered. Not only will it have an effect on Medicare, but I suspect Medicaid as well.

I think we ought to report back to the doctors to how they are doing, confidentially, of course, and individually. We don't tell everyone about every doctor, but let the doctor know how he is doing compared to his peers, how he or she is doing as far as their Medicare expenditures.

You know what? Since we will have the data there, and it's already collected, I think we should share data with the patient as well. How much did your care cost the government last year? Try to encourage patients to do those things to participate in their own care and see if they will not participate in bringing the cost of that care down.

Now, why do I spend so much time talking about this? Because it's a very important concept. Now, in the SCHIP bill, as was passed by the House, there was a modest physician fix for 2008 and 2009. It was less than the CBO scores, the physician fix for my bill, but the reality is, that the SCHIP bill, the physician fix contained within the SCHIP bill did not have as an end point the repeal of the SGR.

I reiterate, if you don't repeal the SGR, you only make the problem worse than in the out years. By 2010, what happens under the SCHIP bill? All those cuts come back, 10 percent, 13 percent reductions in payments to physicians that year alone, and it continues year over year for the remainder of that budgetary cycle.

In fact, the scenario, as it was described to me, is modest update in 2008 and 2009, you fall off a cliff in 2010, and you are frozen in 2013. It doesn't sound like an attractive proposition to me.

There is a way forward in this that makes sense. I encourage Members of Congress to look at 2585. It is a reasonable alternative to what was proposed in the SCHIP legislation. The reality is, as we all know, the SCHIP legislation is going to change radically before it ever sees the light of day. It's unclear and uncertain at this time whether a physician fix will, in fact, survive in that bill.

Whatever minutes I have left, I want to talk for just a little bit about medical liability reform, because I think this is an issue that this House still needs to address. My home State of Texas, now going on 4 years ago, September 12 of 2003, passed a major piece of legislation that was modeled after a bill passed in the State of California back in 1975.

I hate to admit that California was ahead of the curve on this, but the Medical Injury Compensation Reform Act of 1975 passed in the State of California, which capped noneconomic damages, had a very, very significant effect on what, at the time, was an out-of-control liability climate in that State.

The State of Texas adopted a similar program in 2003, modeled after the Medical Injury Compensation Reform Act of 1975 in California. The Texas bill actually puts a $250,000 cap on noneconomic damages as they pertain to the physician, a $250,000 cap on noneconomic damages as it applied to the hospital, and a second $250,000 cap on noneconomic damages if there is a second hospital or nursing home involved, for an aggregate cap of $750,000 for noneconomic damages. Actual medical injuries are paid at the actual rate, but noneconomic damages are capped at $750,000 under the Texas law.

This was a major, major change for Texas when this happened back in September of 2003. We had been undergoing many years of 20 to 30 percent increases in premiums for physicians' practices in Texas. In the late 1990s, we had 17 medical liability insurers in the State of Texas. In 2002, we were down to two medical liability insurers in the State of Texas. The rest had fled because the litigation climate was so unfavorable in my home State of Texas. You don't get very much competition. You don't get your very best competitive rates when you have only got two companies continuing to write business in your home State.

In 2003, we did pass the medical liability reform based off the California law, and a legitimate question to ask is how has Texas done since then? Remember I said we dropped from 17 insurers down to two, because the medical liability crisis rose very quickly. Within 2 years' time, we were back up to 14 or 15.

I don't know the total number today, but I believe it is either in the high 20s or perhaps even as high as 30 carriers in the State, a significant change from the environment from just 4 years ago. Most importantly, the carriers that have come back to the State have returned to the State of Texas without an increase in their premium.

In 2006, only 3 years after its passage, the Medical Protective Insurance Company had a 10 percent rate cut, which was its fourth reduction since April of 2005. Texas Medical Liability Trust, my last insurer of record, declared an aggregate of 22 percent cuts. Advocate MD, another company, filed a 19 percent rate decrease, and Doctors Company announced a 13 percent rate cut. Real numbers, real numbers that affect real people and affect real access for patients in a State that realistically was in peril in 2002, a significant reversal. More options mean better prices and a more secure setting for medical professionals to remain in practice.

One of the unintended beneficiaries of this act was the effect on small community not-for-profit hospitals, the type of hospital who would have been self-insured for medical liability.

They have been able to take money out of their escrow accounts and put it back to work in those hospitals to capitalize improvements, pay for nurse's salaries, just the kinds of things you would want your small, medium-sized not-for-profit community-based hospital to be doing, not holding money in escrow against the inevitable liability suit that might occur.

I took the language of the Texas plan, worked it so it fit with our constructs here in the House of Representatives. I took that language to the

ranking member of the Budget Committee before we did our budget vote earlier this year.

Representative RYAN, Ranking Member RYAN on the Budget Committee had that proposal scored by the Congressional Budget Office. The Texas plan, as applied to the House of Representatives, to the entire 50 States, would yield $3.8 billion in savings over 5 years' time; not a mammoth amount of money, but when you are talking about a $2.999 trillion budget savings of any size, moneys that we will leave on the table in this budgetary cycle that could have gone into some other spending priority, I've got to ask you, I've got to tell you, I just frankly do not understand why we would not look more seriously about taking up that type of plan.

Now, on the fourth anniversary of the passage of the Texas plan, I do intend to introduce this legislation. I think it is commonsense legislation that would bring significant relief to our doctors in practice and be a significant source of monetary savings for this House.

If Texas is doing such a good job as a State, why do I even care about it? Why do I even bring up that maybe we ought to look for a national solution?

Well, consider this. A 1996 study done at Stanford University revealed that in the Medicare system alone, that's a system that we pay for, that we have to come up with the money for every year, in the Medicare system alone, the cost of defensive medicine was approximately $28 to $30 billion a year.

That was 10 years ago. I suspect that number is higher today. That's why we can scarcely afford to continue on the trajectory that we are on with medical liability in this body and in this country. Again, I frankly do not understand why we will not embrace and capture those savings that are sitting out there within easy reach.

I began this hour talking about the physician workforce, and let me conclude this part of the liability discussion by coming back to the issue of the physician workforce.

No other issue in the practice of medicine, and I speak to you for someone who had a medical license and who still has a medical license, but it was an active practice for over 25 years before coming to Congress. No other issue grates on the sensibilities of a doctor in practice as a constant concern about a medical liability suit. We go into practice to do good work. We go into practice to do good things.

If a mistake is made or if an outcome is bad, it doesn't always mean that the next step has to be a trip to the lawyer's office and going through one of these egregious, emotionally trying lawsuits. That's one of the things that keeps young people away from the practice of medicine. They look at it and they think, well, it will cost me an awful lot to get that education. You know what, those courses are real hard, and by the time I get there, I will have to pay an enormous amount of money for my liability policy, and I don't even want to think about what it would be like if I actually got sued.

Young people getting out of college, are they considering medical school under those conditions? Unfortunately, a lot aren't.

We are keeping some of our best and brightest young people out of the health care profession because of the burden that we put upon them, the burden economically that we put upon them to get that education, just the burden that the education itself entails. It can't lighten that burden. It takes a lot of effort to study medicine. It takes more effort, I would suspect, here in the early 21st century than it did late in the 20th century when I was in my medical school classes.

But we have to consider the emotional price that we are asking young people to pay if they are go into the practice of medicine. It is within our grasp to reform this system. It is within our best interest as a country to reform this system, and financially, it makes tremendous sense to reform this system.

So I ask other Members of Congress to join me when I introduce this legislation later this month. This, again, is a commonsense, practical approach, proven in the laboratory of the States, my home State of Texas, to be a proven and effective method of reducing the cost of medical liability.

You have been very indulgent this evening.

## AMERICAN PATENT LAW

The SPEAKER pro tempore. Under the Speaker's announced policy of January 18, 2007, the gentleman from California (Mr. ROHRABACHER) is recognized for 60 minutes.

Mr. ROHRABACHER. Mr. Speaker, tonight I would like to raise a red flag to draw attention, the attention of my fellow Members, who are here assembled, as well as those listening on C–SPAN and those who will be reading this in the CONGRESSIONAL RECORD.

On Friday, legislation is scheduled to come to the floor of the House that will have a huge impact on the American people, yet it is receiving little attention. What is it? It is a proposal to dramatically diminish a constitutionally protected right by fundamentally altering America's patent system.

If H.R. 1908, the bill in question, passes, there will be tremendous long-term negative consequences for our country.

Patent law is thought to be so complicated and esoteric that most people tune out once they realize that's what the subject is. Yet our technological genius and the laws protecting and promoting that genius have been at the heart of America's success as a Nation. America's technological edge has permitted the American people to have the highest standard of living in the world and permitted our country to sail safely through troubled waters, the troubled waters of world wars and international threats.

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American technology has made all the difference. And it is the American patent law that has determined what technology, what level of technology development that America has had. Protecting individual rights, even of the little guy, has been the hallmark of our country. Patent rights, the right to own one's creation, are one of those rights that are written into the United States Constitution. In fact, Benjamin Franklin, Thomas Jefferson, George Washington and others, all our Founding Fathers were not only people that believed in freedom, but they also believed in technology and the potential of American genius. Visit Monticello and see what Thomas Jefferson did with the time after he penned the words of the Declaration of Independence and after he served as President of the United States. He went back to Monticello and he spent his time inventing things, inventing pieces of equipment and technologies that would lift the burden from the shoulders of labor.

And then there was Benjamin Franklin, again, a man who participated in the Declaration of Independence as well as the Constitution. He was the inventor of the bifocal. He was the inventor of the stove that kept people warm. Until then people only had fireplaces. He had many other inventions to his name. Yet he was also a man, one of our cherished Founding Fathers, who helped us create this free Nation. He believed in freedom and technology and believed that with freedom and technology we could increase the standard of living of our people, not just the elite, but of all the American people.

We have had the strongest protection system in terms of patents in the world; and that is why, in the history of humankind, there has never been a more innovative or creative people. It didn't just happen. It happened because in our Constitution, our Founding Fathers saw to it that the laws protecting one's intellectual creations, both technology and written communications, that those creative people would own their creations. No, it's not just the diversity of our society that has created the wondrous standard of living that we have all bragged about. This is not simply the diversity of our people and some notion that we have by coming from all over the world that has created the idea that all people should have opportunity and provided our people with opportunity. No, the innovation and progress and opportunity that we've enjoyed in America can be traced to our law, the law that protected the property rights of our people, just as we protected the political, just as we've protected the personal rights of our citizens.

Eli Whitney invented the cotton gin. But he also invented interchangeable parts for manufacturing. How did that